ADMINISTRATION, KANSAS DEPARTMENT OF

Moderator: Mindee Reece
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10:00 a.m. CT

Operator: Good morning. My name is Kristie and I will be your conference operator today. At this time I would like to welcome everyone to the Ebola Update Conference Call.

All lines have been placed on mute to prevent any background noise. After the speakers' remarks, there will be a question and answer session. If you would like to ask a question during this time, simply press star then the number one on your telephone keypad. If you would like to withdraw your question, press the pound key. Thank you.

I will now turn the call over to Ms. Mindee Reece.

Mindee Reece: Good morning everyone. We are coming to you live from KDHE Department Operations Center this morning. For our agenda today, we have a situational update we're going to share. We're going to give you some updates about our Kansas Ebola Preparedness and Response Plan and we're also going to review some of our upcoming state-level preparedness activities related to Ebola, then we'll open it up for your questions and our answers.

At this time, I'm going to turn it over to Dr. Moser, our State Health Officer and Secretary of KDHE, and also Charlie Hunt, our State Epidemiologist, will be speaking this morning.

Robert Moser: Good morning everybody. Again, thanks for joining us. We have so much information obviously to update you on. And again I just want to take the opportunity to thank all of you for the work you do and for working with us in communicating issues, concerns, and helping with our plan and response efforts.

I also want to take the opportunity to thank a few of the local health departments who have communicated regarding some of their concerns on the flu vaccination supply and some of those issues and to let you know we are working through those details and issues.

But again, please continue to encourage flu vaccination within your communities and hopefully also within your health care workforce. We have obviously seen this coming up and need to be quite aware of that.

Also, for those of you who may not have seen the news yesterday the FDA approved the type B meningococcal vaccine that was – that they had at a couple of universities. One on the east coast, one on the west coast last year, and so that's been approved to add to our list of available vaccines.

The ACIP will probably come out with recommendations on how to incorporate that into the vaccination schedules for young adults and adolescence by December I suspect, but stay tuned on that.

But otherwise, I'm going to turn it over to Charlie Hunt, our State Epidemiologist to kind of give you a situational update on where we're at on our response guidelines.

Charlie Hunt: OK. Thank you very much Dr. Moser and good morning everyone. I'll cover basically three topics for you this morning, but first I'll provide a brief situation update from the national perspective. I will also – have some information related to the active monitoring protocol that we'll be utilizing in Kansas. And then finally I'll be discussing a few changes that we've made to our preparedness and response plan.

So first of all, you all might have heard yesterday that the World Health Organization has conducted a comprehensive review of patient databases and has substantially increased the number of total cases of Ebola virus disease in West Africa and other countries. It's important to note that this is not a result of increased incident so the increase in cases is simply reflecting the better assessment of existing cases and these cases have occurred throughout the epidemic.

The new total is 13,676 cases and this is in the Western African nations of Guinea, Liberia, and Sierra Leone. So that again is a dramatic increase over the previous estimates.

As you're probably aware, we had one case each in Mali and Senegal and these have been travel-associated cases. And then of course Nigeria, Spain, and United States have all had cases as well.

Nigeria, as I mentioned last week, has been taken off the list of countries that's considered to be at risk of Ebola virus disease. We all have a few questions about the Democratic Republic of the Congo. The efforts for the entry screening process are not focused on travelers from the Democratic Republic of the Congo, but I have not seen any indication that that outbreak has been declared over. And so, we are still considering it as we assess travelers who are coming back to Kansas.

The CDC released updated guidance for monitoring and movement of persons with potential Ebola virus exposure on October 27th. And in conjunction with that, they also released new information regarding epidemiologic risk factors and then case definition.

This information, these guidelines, CDC is using to guide their public health actions during the enhanced entry screening process at the five U.S.airports that are now receiving all travelers from Guinea, Liberia, and Sierra Leone. And again, that does not include the Democratic Republic of the Congo.

And I think it's important that we keep in mind that there is some anecdotal evidence that suggest some travelers that have been in these countries may still be arriving in United States somehow but are not undergoing the active screening process. So for example, if they are departing from a different country but they had local travel within those areas, they may not be assessed.

So, even though this enhanced screening process is being conducted at the five U.S. airports, it's important that if you are aware of anyone that has been traveling in one of the affected countries that you are still conducting the risk assessment process with them.

The CDC guidelines are now closer to the KDHE guidelines, but there are some differences that remain and again, we are – we and the local health departments and health care providers are going to be utilizing the KDHE guidelines.

I think one of the distinctions particularly for the local health department staff is that the new CDC guidelines recommend direct active monitoring of persons that are coming back for 21 days. In our guidance, we stated very clearly that we recommend that that the monitoring should be conducted via telephone or video conference and not be conducted in person.

But nonetheless, the principle is some form of active monitoring for 21 days for essentially all persons that are returning from one of the Ebola-affected countries. CDC is now recommending that as well, and so that is consistent with our guidelines.

With the enhanced entry screening process and the information that we are getting from CDC, we have developed an active monitoring protocol and we'll be finalizing that and giving that out to local health departments shortly. This protocol will deal with how information is received on the returning travelers via EpiX. Again, we will get a daily e-mail and information through EpiX on any returning travelers.

We in turn will notify the local health departments that have the traveler residing in that county. We are taking under consideration some convenience issues. So, for example, one of the things that we're going to propose is that we will only call before 9:00 p.m. and recommend that you will not contact travelers after 9:00 p.m. But again, we'll – these are things that we can discuss. If you have any recommendations or concerns about that, please let us know.

If we are not able to contact the local health department with information on a returning traveler within four hours, then we will initiate the contact with the traveler ourselves. And then we'll hand that off to you as soon as we're able to get in touch with you.

We are also setting up EpiTrax to allow us to help with the monitoring process, and so we think that this will be a great help to you and to us as well.

We'll be hosting a webinar for local health department staff next Wednesday, that's November 5th from 1:00 to 2:00 and we'll be sending out detailed information about that webinar shortly. And again, this will be to go over the protocol and how to use EpiTrax for this process.

And then finally, we did release version 2.1 of our Ebola Preparedness and Response Plan on October 27th. Although there were some changes in format, the primary difference was that we updated our personal protective equipment guidance. Most of the changes deal with terminology that we are utilizing and the disinfection process during doffing. And we also included some guidance on the outpatient settings and that's in response to a lot of questions that we have been receiving.

And then finally, we included a waste management flowchart and that's at the very back of the plan.

We will – obviously, need to continue to make updates to the plan as new information becomes available from CDC and from questions that we're getting. We'll make revisions as appropriate. For minor issues, we probably will only release the updates once a week and we are working on some formatting to make it easier for you all to access and print off only those updated sections or the sections that you are interested in.

And with that, I will turn it back over to Dr. Moser.

Robert Moser: All right. Thank you, Charlie. The other activities that we've been working on have been the conversations with some of our hospital folks today. Tomorrow, I will continue to reach out to some of our larger hospital CEOs either by e-mail or phone, but to continue with some conversation around some of our preparedness plan.

As mentioned early on, we build in the most appropriate location of treatment for these folks who are in the center that have the experience and preparation such as the biocontainment units. And since we would be

involved early on, notification of a highly suspect case at KDHE, we would be contacting CDC to make arrangements for the testing and for confirmation.

And during that time frame, we would also be reaching out to contact CDC and University of Nebraska Medical Center for the possibility of a transfer of a patient that would involve us also putting on standby the biocontainment transport unit assist with the transfer of a patient. But there are still some issues around that, obviously. It all depends on whether the facilities have the capability at the time we might need them whether they could accept the patient.

This is part of the reason we still talk about facilities needing to have the capability at least for managing a patient or a couple of days while all of this is taking place. But we do appreciate all the work that's been going on.

As many of you I know have been involved at the community level and perhaps, some of the regional levels regarding some of the tabletop or just seminar type discussions to look at where you stand with your level of preparedness. We are going to be utilizing a couple of things, I think to gather a little bit more information to get a broader picture of what the status of our health care systems and public health systems are across Kansas.

And with that, I'm going to turn it over to Mindee to go through that in some detail. It will be basically asking for completing a survey. And I promise, this is a very short survey and it won't be repeated everyday. It's just more to get a baseline and then at some point of time down the road, depending on the initial results, we'll look at updating that again.

I'll turn it over to Mindee at this time.

Mindee Reece: As Dr. Moser mentioned, we are getting ready to launch a survey through to EMSystem or EMResource for hospitals to assess their level of readiness. We have developed a set of questions. I think there are 12 to 15 questions total and we've been working with the Kansas Hospital Association to look at those questions and make sure we're framing them in the most meaningful way. They're yes or no questions.

Those will be released later today for all of the hospitals to address through EMSystem. We will send a notification through the Kansas Health Alert Network to the hospitals to let you know when that survey is released so that the individual with the information in the hospital can respond and not just the folks in the Emergency Department where most access to EMSystem is within a hospital setting.

Also planned, is a series of regional health care coalition Ebola preparedness forums. And I want to acknowledge the hard work of the regional hospital coordinators and Ron Marshall with the Kansas Hospital Association and working with KDHE to get this scheduled and planned so quickly.

I want to walk through the dates so all of you will have that information. And the first meeting will be held on November 17th, that's for the Kansas City area, regional health care coalition. It will be held at the Johnson County Annex Building in Olathe from 8:30 a.m. until noon.

On November 19th, we'll be in Wichita at the K.U. School of Medicine in the Robert Amphitheater, and that meeting runs from 10 a.m. to 3 p.m. On November 20th, we'll be in Topeka with that regional health care coalition. The meeting will be held at St. Francis Health in the auditorium from 1 to 5 p.m. On November 21st, we'll be in Salina, from 9:30 a.m. to 2:30 p.m. That location in Salina is still being determined.

On November 24th, we'll be in Hays. And that meeting runs from 10 a.m. to 3 p.m., location – specific location is to be determined. November 25th, we'll be in Chanute, at Neosho Regional Medical Center in the first floor training room, from 10 a.m. to 3 p.m. And just scheduled at 9:58 this morning we'll be in Garden City on December 16th at St. Catherine Hospital, from 10 a.m. to 3 p.m.

All of these meetings are available for registration on Kansas TRAIN, our learning management system. So, please do register your plans for participation. We encourage broad participation among the many disciplines that will be engaged in dealing with an Ebola patient and the associated contact tracing and ancillary services that fall into that realm of care.

The format of meeting has changed since our regional communication with the regional hospital coordinators and with the Kansas Hospital Association, so I apologize for that that our plans as they now stand, offer a team of folks from KDHE, that will include Dr. Moser, Aaron Dunkel, our Deputy Secretary, Charlie Hunt, our State Epidemiologist, Myron Gunsalus, our Laboratory Director, a representative from our Division Of Environment, and me, I will be there too and we're going to attend all of these meetings.

The plan is for us to provide a situational update based on the information available to us at that time, to walk through our Kansas Ebola preparedness and response plan, and then, to open it up for discussion and questions and answers. And our commitment is that we will stay until we have addressed every issue, every concern, every question that the participants have. So that's why the meetings have been scheduled for more than an hour or hour and a half.

We want to make sure that while we're face to face, that we can discuss and walk through any of the issues, concerns, questions, brainstorm as appropriate to address all of the things that are pertinent to the participants.

Originally, we had planned that we would breakout with each discipline separately and that's the big change as we're going to keep everybody together because we believe that the best conversation in communication will take place across discipline and not just discipline specific. This was a change that KDHE determined after we had originally communicated with our regional hospital coordinators.

We're excited to be traveling across the state and I hope to see many of you face to face as we make our rounds. We also are scheduling another Ebola-focused call for a week from today which would be Thursday, November 6th, also at 10 a.m., that information will be sent to all of you via the Kansas Health Alert Network and other means that will also be posted on our Web site later today.

The last update I want to provide is that we're in the process of developing a training plan for the individuals who have volunteered to our Kansas system,

for the early registration of volunteers to serve on our regional bio response team. As of today, we have between the individuals from our department who volunteered and professionals from across the state; more than 40 individuals who have volunteered to work in a health care setting, in a local health department, a hospital to provide direct support to the work around caring for an Ebola patient.

We're developing plans for HAZWOPER training and some other just in time training for those individuals. That information will likely be available next week. And if any of you have interest in participating on that bio response team, please e-mail us at response2014@kdheks.gov. I'll turn it back to Dr. Moser then we take your questions.

Robert Moser: Yes, I think at this time we'll just go ahead and get right to the questions and provide some updates and answers accordingly.

Mindee Reece: OK. Kristie we're really to open the line, please.

Operator: At this time I would like to remind everyone, in order to ask a question, simply press star then the number one on your telephone keypad. Again, that's star then the number one to ask a question. Your first question comes from the line of Liz Ticer.

Mindee Reece: Good morning Liz.

Liz Ticer: Hi. Good morning Mindee. I just wanted to – actually I don't have a question, I wanted to clarify the Kansas City area health care coalition meeting is actually at the Johnson County Administration Building at 111 South Cherry downstairs in room 200.

Mindee Reece: OK. So the Johnson County Administration Building, 111 South Cherry, and is that in Olathe?

Liz Ticer: Yes ma'am.

Mindee Reece: OK, very good.

Liz Ticer: Thank you.

Mindee Reece: Thanks for doing that.

Operator: Your next question comes from the line of Steve Granzow.

Mindee Reece: Hi Steve.

Steve Granzow: Hi, good morning Mindee, how are things going?

Mindee Reece: Just dynamite.

Steve Granzow: All right. Great, glad to hear it.

I understand and I appreciate the regional response team that you're developing. Is there any plan to provide local communities, a cache if you will of optimal personal protective equipment so that we can adequately begin the management of these suspect Ebola cases until the emergency response team arrives?

Mindee Reece: I would say that if you have exhausted or feel you're going to quickly exhaust the personal protective equipment that you have, or if you are unable through your usual sources to obtain the personal protective equipment, you need to work through your local emergency manager to make a request through the normal process for materials from the state.

We do have a cache of personal protective equipment that we have purchased with preparedness funds that may or may not be what you're looking for, but that would be the way to handle that. We also would ask that you talk to your regional hospital to see what resources they might have before you make the request through your local emergency manager, but that's the typical process we follow and we'll be utilizing that through the Ebola preparedness and response activities.

Steve Granzow: Well, OK.

Mindee Reece: OK.

Operator: And your next question comes from the line of Karen Luckett.

Mindee Reece: Hi Karen.

Karen Luckett: Hi guys. I just wanted to know if you could give the I.D. for the Kansas TRAIN, the I.D. number for the Kansas TRAIN so we could send it out for people to sign up.

Mindee Reece: The Garden City – the whole – sorry, all of the training the Ebola preparedness forms at the coalition meetings, the course number is 1053984. So I'll repeat that for all of them, in all areas, its 1053984.

Karen Luckett: OK, thank you very much.

Mindee Reece: You're welcome.

Operator: Your next question comes from the line of Kristie Bunker.

Mindee Reece: Good morning.

Kristie Bunker: Hi, I am from a critical access hospital and I just had a question regarding our laboratory, we didn't have a set up where we have an area to have an isolation area to run the test. Would it be feasible to use our backup portable equipment and bring it to our isolation unit and set up a laboratory there to run rapid test and CBCs?

Myron Gunsalus: Kristie this is Myron Gunsalus with the laboratory. Most of the tests that you would be doing, we've been working Dr. Moser, most of the tests that you'd want to be doing would be very limited and ideally point of care testing. So you don't run the risk of contaminating your regular laboratory.

So, if you need to set up a separate place in an anteroom or a separate room for any testing you will be doing knowing that that equipment and that everything in that room would need to be decontaminated after. If it was determined to be positive then, yes, that would be a good idea.

Kristie Bunker: OK, and also the equipment that we use for our chemistries is too large to do that. I mean it is right in the middle of our laboratory. Is there any guidance

on how we could send those out to have those tests run because that might be information that the providers will need?

Robert Moser: Yes, this is Dr. Moser, and if you're talking about a case that's yet to be confirmed but it's a case that's highly suspicious, basically the handling of that specimen requires a proper shipping requires you to notify who you're sending this to. And so, basically I would probably reach out to the reference labs you currently use as to what their preference is.

Whether they would accept that number one, two, how they would like to be notified if you're going to be sending something else. But some of the point of care testing equipment can provide for the basic CBC electrolytes and such and, if you're really gearing up toward, providing care for such a patient would require this type of isolation.

Getting that type of equipment that could be placed and left within those areas where it's protected from spreading the contamination across the system would be ideal.

Kristie Bunker: OK, thank you very much.

Operator: Your next question comes from the line of Sharon Scheid.

Sharon Scheid: Yes, the question we have is, we're in a rural hospital. And, if somebody should show up to the E.R. door with signs, when a nurse walks up to him and initially – does the initial questionnaire that we are considering putting our nurse initially in a mask and just a protective gown and having the individual stop if they have a fever.

But the question is, is after they do the initial assessment according the questions that you have, and then all of sudden they think they're a positive – a possible case. At that point in time, do you have guidelines to what the nurse does right there like do we have them step out of the room, disrobe, get back into something else and then go back and move the patient.

Is there some guidelines there because, I think we've got a little break as to the first evaluation and a positive on their evaluation.

Robert Moser: No, great questions. And I think this is important for, each facility, kind of based on their physical lay out, the normal day to day operations on how to best handle it. Obviously, part of the importance of speaking with everybody that maybe first contact for a patient is to be mindful of asking about the travel history. So that hopefully these patients would be identified as early as possible before we start dealing with direct contact with that patient, with the health care personnel.

If, unfortunately, the patients in front of a nurse and you've got – basically what you're describing is correct, we should be always mindful of universal precaution approaches. And using the three feet physical separation which we know is protective in itself, to first gather that information and determine what the risk factors are.

And if positive that patient should be immediately isolated. For the personnel if they've had no direct contact with the patient, the likelihood of having any contamination on them is obviously pretty low but you're right, they should obviously immediately go and put that clothing into proper biohazard bag. Put on different clothing and proper PPE before going back in to provide direct patient care.

Sharon Scheid: OK, thank you. That was my question on just the end term whether do we step out and do we need to wipe down with the Clorox, the outside of the gown and stuff as we disrobe and then get into the other stuff or – I'm understanding that as long as we maintain that three feet we should be – pretty slim and we could disrobe appropriately and then get right into the other material.

Robert Moser: Yes, yes, steps would be basically as you described. And indeed if they kept that separation, doffing that equipment so that you're basically pulling it, folding it inward and only touching downward surfaces, thorough handwashing before grabbing any other clothing that you might put back on so that you're not just contaminating from one to – once you go back into.

We do have on the preparedness response plan on page 11, special considerations for outpatients settings and I realize not all the details, in a step

by step manner of how to approach this is necessarily in there but this is again why we would like to have folks, to come and sit around the table talk about it, actually go through physical walk through and in some cases as to how they might manage that within their particular locale.

Sharon Scheid: OK, thank you.

Operator: Your next question comes from a line of Beth Heppala.

Beth Heppala: Yes, hello.

Mindee Reece: Hello.

Beth Heppala: I have a question for you about the difference between your guidance and CDC guidance. You are requiring the use of a PAPR for optimal coverage although the CDC says that you can use and N95 or a PAPR.

And the other difference is that, CDC views health care workers who are using appropriate PPE to be at low risk, and it looks like you are viewing them to be more at high risk because you are going to – if they're not using a PAPR, or full body coverage which really you guys are requiring are PAPR, you're still going to restrict them from public activities and from travel. So can you make a comment on that, please?

Charlie Hunt: Yes, and this is Charlie Hunt and indeed our guidance is different than CDC guidance and the recommendations that we have made are our position of that the health care workers here as they're caring for a patient with Ebola virus disease.

And I do want to make one correction to the statement that CDC does draw a distinction between health care workers who are providing care in one of the Ebola affected countries in Africa versus health care officials who are providing care here. For staffs that are providing care in Africa, CDC is classifying them as not high risk, but it's different here.

Beth Heppala: Yes, you're right. I'm sorry that's correct.

Charlie Hunt: No, it's OK. So and again I think with respect to the requirements for restricted movement, again we want to make the distinction that the movement is restricted except with permission from the local health officer. So, the goal here is to provide that opportunity for there to be a discussion about planned activities and how to minimize any potential risk associated with those activities. Though somebody needs to leave their home, they're discussing those plans with the local health officer, and again just doing the best to minimize any potential risk associated with that.

Beth Heppala: Thank you for that clarification.

Charlie Hunt: Thank you.

Operator: Your next question comes from the line of (Jim Jorkie).

(Jim Jorkie): Good morning. On last call there was a question about the implications of processing Ebola infected waste, for waste water utility operators, and I was wondering if there has been any communications between KDHE with the waste water operators and what the new guidelines are for us.

Robert Moser: Yes, this is Dr. Moser. Thanks for the question. We do know that our Bureau of Water Director Mike Tate has sent a letter out to the folks within any community that has a hospital to kind of bring in to the discussion our recommendations from managing the body fluids part of disposal into the sewer system.

And so, the conversations are currently ongoing as far as the management of that. So we would expect I think by the end of this week they have kind of an update on any of the waste water treatment facilities that have any contended issues with the proposals on how to manage that bodily waste from an Ebola patient. And then we'll follow up with it from there.

Again, I think this is mostly education and reassurance and everybody kind of working together on how to best manage this so that we decrease the risk of possible cross contamination.

(Jim Jorkie): OK. And that is something that KDHE would also share with non-waste water entities?

Robert Moser: Yes.

(Jim Jorkie): OK, thank you.

Operator: Your next question comes from the line of Susan Cooper.

Mindee Reece: Hi (Sue).

Susan Cooper: Hi, good morning. I have a question from our lab director, she says that her concerns are with the labs that cannot be done by point of care, she specifically talks about typing and cross matching, what she said that the guidance say that you can give O neg or O positive, whatever. But at some point, that blood work has to come to the laboratory for a cross match and the equipment that you need for that is very difficult to put into an alternate location, dedicated just for Ebola.

So, how do you take those assessment within the hospital to the laboratory to run what needs to be monitored and then how do you clean the lab equipment so that you're sure it is not infected?

Myron Gunsalus: (Sue), this is Myron, in our guidance document at the back and towards the back of appendix 6 is the guidelines from the American Society for Microbiology, and that guidance specifically addresses how to transport a specimen, how to take a specimen, how to decontaminate the outside, and how to transport it within the hospital. On the other side, again one of the recommendations from CDC is to do, very minimal testing back in the laboratory because decontaminating the equipment is a potential challenge if that the patient were to be determined to be a positive, confirmed Ebola case.

Robert Moser: It's a great question as you continue to work through the details of patient management and a very complex management complex setting. We are also looking at how bio containment units are managing these and in most cases, they have basically provided for most laboratory equipment to be right there within that setting.

So that is a challenge and as we continue to learn a little bit more about how they've been able to successfully manage patients like this and provide for the information providers need to direct that treatment. So we'll probably – as we mentioned earlier, continue to provide some finer detail and recommendations as we continue to learn from some of the experts that are dealing with these cases.

Susan Cooper: OK, just to follow up, you did say that you are working with – through the Kansas Medical Society or association for guidance physicians to know what they should be ordering. Did I understand that correctly?

Robert Moser: Didn't really say that, but we are obviously providing through Kansas Medical Society a great deal of our information and guidelines so that they can get those out to providers. We were just talking about the recommendations from the American Society of Microbiology, the proper handling of lab specimen from Ebola patients. And that's appendix 6 in our planning and response guideline documentation.

Susan Cooper: OK, thank you.

Minda Reece: Thank you.

Operator: Your next question comes from the line of Ladonna Reinert.

Mindee Reece: Good morning Ladonna.

Ladonna Reinert: Good morning. The statement was made earlier that there might be some people that get through the airports or whatever by – that aren't screened. Are there some mechanisms to check to see if they really traveled? I mean, are we supposed to be making sure they really traveled, look at their passport or do anything? Is there some mechanism for that?

Charlie Hunt: This is Charlie Hunt. Again, what I was alluding to is that if you become aware of someone that has traveled and has not – did not go through the entry screening process and the risk assessment process, so somehow, they got

through this system. Then, we are recommending that you go ahead and do that risk assessment process.

Right now, the entry screening process that's going on in the five airports is the best system we have in place right now, but like I said, there's an anecdotal evidence that it's not perfect and that there's still a small chance that travelers would arrive either through some other country, even though they had been in one of the Ebola-affected regions, if they're flying back from some other country for example, they might be missed.

So if you become aware of somebody that that happened to, go ahead and conduct the risk assessment.

Operator: And your next question comes from the line of (Jane Rosalin).

Mindee Reece: Good morning.

(Jane Rosalin): Good morning. I just want to double check. I have at least two people that have given us prior notice of travel to non-risk areas of Africa, Kenya, et cetera, and which would put them in the no significant risk category from the CDC, but in the light of the – however you want to call it, reaction in New York with the quarantine and attempt of someone who was, I understand is a non-risk category. I just wanted to double check with you to make sure that there was quarantine guidance from KDHE.

Robert Moser: Yes. Correct. Just for clarification, the person in New Jersey was actually a health care provider caring directly for Ebola patients. So she was in a high risk category and so, properly, should be actively monitored according to not only our guidelines but also CDC's.

Now, indeed, we, have pointed out to a few other calls in the past of travelers coming from, Kenya, Somalia, countries that do not have any active ongoing Ebola epidemics or outbreaks ongoing. So again, part of the case definition for determining risk is whether or not they have traveled and been involved with the three countries in West Africa.

So the other countries, other than the Democratic Republic of Congo – so I guess, I'll say, the four countries that have currently active Ebola cases ongoing, those are the only four countries that you really need to worry about when you do your travel history questionnaire.

If they indeed say, no, I just got back from a trip in to Kenya then indeed, they fall into that no risk category.

(Jane Rosalin): Thank you.

Operator: At this time, again, if you would like to ask a question, press star then the number one on your telephone keypad. Again, that's star then the number one.

Your next question comes from the line of Steve Hoeger.

Mindee Reece: Hi Steve.

Steve Hoeger: Hi Mindee. Good morning Dr. Moser and all. A couple of questions with fatalities, the guidance from CDC was the body needed to be triple enclosed with a shroud in two body bags. There was some opinion that the KDHE guidance was different from that new advice on that?

Robert Moser: Yes. We'll double check our guidelines here, Steve to confirm. We've had a lot of conversations with our Kansas Funeral Director Association that's been engaged in other discussions around on, the proper handling of the body and to some degree, I would also say, that they may have some preference on how to prepare the body for their acceptance and transport.

And we've had a lot of questions around, obviously the recommendations are for cremation, but if for religious reasons, that's not acceptable, then that has to be buried and medically sealed casket. So Charlie here has pulled up our current guidelines. I'll let him take it from here.

Charlie Hunt: Yes. I think again, looking at our guidelines, we're suggesting that the triple layers of leak-proof packaging during transport and storage of human remains, which at the time, this was written with higher than the CDC recommendation.

So again, we will review the most recent recommendations with CDC and make adjustments accordingly.

Steve Hoeger: OK. So, just maybe a clarification then a couple of secondary questions with that, shrouding would be the first layer and double packing would then provide two additional layers. So, that would meet the three layers with what you're describing. So, yes, just clarification if that works.

Charlie Hunt: Right. Correct. And decontaminating the outside of the first body bag prior to placing in that second one.

Steve Hoeger: Sure. Great. And then, implantable devices such as pacemakers and implantable pacer (AEDs) have a huge issue with cremation…

Charlie Hunt: Right.

Steve Hoeger: … any guidance with that. And then, there was – I know on at least one conference call and I can't remember if it was CDC, KDHE or who, there's a time frame given for final disposition of bodies, talking about 24 to 48 hours and if they weren't embalmed, but I haven't seen that in writing anywhere, is there a guidance on that?

Robert Moser: Yes. No, that's true. The recommendation was to have that managed within 24 hours. And so, that'll be part of the update to our plan which will be available probably the first portion of next week. We probably won't update our plan anymore frequently than that. So as Charlie mentioned earlier, the breakdown of this section and such will make that a little bit easier. But we will be looking at the handling of the body providing more of those details within this next update by the first portion to middle of next week.

Steve Hoeger: Great. Thank you all.

Mindee Reece: Thank you.

Operator: Your next question is a follow up from Susan Cooper.

Susan Cooper: Hi. I think that's a good question that Steve has asked. What I don't understand is how you take someone who has died, the environment that

they've died in is contaminated, and you're putting them in a shroud. You're disinfecting the body bag, whatever, how do you make sure that you are not transmitting anything? I don't know if you understand what I'm saying, but the body isn't going to go to another room to await transport.

Robert Moser: No, it's a great question. And again, this is something that I think, we don't always have a great deal of experience with the step by step process and where I think it needs kind of walk through this. So if the body is on a bed, is it possible to bring in a sterile sheet or, plastic if you would to be able to essentially the best you can, wipe down but lay that body over on to that to wrap it, and then to move into the body bag.

So I think there are some steps to consider because you're absolutely right. We would ideally be putting that into the body bags in a room that is likely contaminated on many surfaces and so they have to be consciously aware of that and also the purpose behind carefully decontaminating the bag before you place it into another one. But I think we have to start with determining how we best prepare for a clean surface if you would as we move the body from one spot to the next.

Susan Cooper: OK. Thank you.

Operator: Again, if you would like to ask a question, press star then the number one on your telephone keypad. Again, that's star then the number one.

Mindee Reece: While we're waiting to see if we have any final questions, I will repeat a couple of items.

We are going to have another Ebola call a week from today, Thursday, November 6th at 10 a.m. In the meantime, please feel free to send any questions that you have to KDHE at our response 2014 e-mail address, which is response2014@kdheks.gov. Before the end of this week which I guess is tomorrow, we will update our FAQs for health care facilities based on the questions we've received on our e-mail address this week and anything we've noted from today's call. So, watch for that on our Web site.

We also will be posting the dial-in information for the next week's call. We will be sending out some information via the Kansas Health Alert Network before the end of the week too regarding the call and a few other items. We're doing our best to communicate with you, if any of you have suggestions or anything that you want to share with us, please do e-mail us at response2014@kdheks.gov.

Kristie are there any final questions?

Operator: Yes, your next question comes from the line of (Gianfranco).

(Gianfranco Pezzino): Good morning, (Gianfranco Pezzino) Shawnee County Health Officer. Could you please expand on the difference in recommendations between the CDC and KDHE required in active monitoring?

My understanding is that the CDC recommends to first place a call with the person under monitoring and make sure the person is not symptomatic and then have a personal visit inside the house without wearing any personal protective equipment.

And KDHE's recommendations, my understanding is, is that, the monitoring should be done at a distance. Could you explain if that discrepancy is going to remain in your future revisions and if so, what – how do we explain the difference?

Charlie Hunt: This is Charlie. I think your assessment is correct. The CDC does recommend doing the direct active monitoring for those in the high-risk exposure category. There is a high-risk exposure category, and there is a some-risk exposure category, and then the low-risk exposure category. If I remember (we're) just suggesting active monitoring, unless they're a health care worker.

So, again we – we just determined that it's best not to extend public health workers out to the person's home or residence to do that, again just maintaining the distance. If you feel that there's some need to do an in-person visit because you think, compliance will be better or for some other reason, and you're certainly free to direct your staff at your health department to do that.

Robert Moser: Yes, great question and we agree. We just think that limiting the number of additional contacts is necessary. But a lot of it does depend on compliance of that individual and we feel most folks would tend to be more compliant and in fact being knowledgeable of the issues that they would welcome the opportunity for – the interaction with the public health department to assure that they're not impacting other's lives.

But we also recognize that while we may look forward, guidelines or recommendations, the local health officer can certainly be more aggressive accordingly.

Operator: At this time we do have a follow up from the line of Kristie Bunker.

(Trisha Morris): Hi this is (Trisha Morris), and in Chanute we had a city-wide meeting on Ebola with the city department managers at the city level and county officials, we have the school district and the junior collage.

So, one of the questions that was raised that I didn't have an answer for was for the volunteer fire departments or other types of first responders, is there a resource for their education and is there any outreach that we could refer them to on Ebola?

Charlie Hunt: This is Charlie, I guess in general the comment I would make is that– as a health care provider if they were – for some reason leading the initial interaction with a patient with potential Ebola disease that they, they would face potentially the same risks, and that they should be very familiar with our guidelines. Look over the guidelines for outpatient settings, for personal protective equipment, et cetera.

And then as far as, for the emergency communications, the 911 centers, CDC does have some specific guidelines on how to – how to deal with calls that are coming in as well.

(Trisha Morris): OK, thank you. We'll pass that information on.

Robert Moser: Yes, great question there. And I think again it kind of points out the importance of communication at the local level. Obviously, the local health department's aware of, a contact case that they're monitoring, making sure that law enforcement is aware. The 911 center would be aware so they can look at that for their information if a call would come in.

So the communication among partners within the local emergency response, whenever we talk about, reviewing the after action reports of exercises, I think communication always tends to be at the top - this could get better. So this gives us some opportunity to look at how we make certain that those who could be impacted are part of the communication chain early rather than later.

Operator: And you do have a follow up from Karen Luckett.

Karen Luckett: Yes, I have a couple of things. One about communication, my concern is, too much communication – as things may wind down a little bit, we're not hearing about new cases in the United States or anything that people are going to start ignoring all of the Ebola communication they get.

And so, I typically, if I get something from HAN or KDHE preparedness, a lot of times I send it out to my region, to the people in my region. And, I know they're probably getting multiple things of the same thing. But, I'm not sure. So, I go ahead and err on the side of sending it. But, should I just inform them that they need to be very aware of Kansas HAN and be on top of that? Or should I just keep sending them, probably what are repeat e-mails?

Robert Moser: Yes, another great question Karen and I can tell you that one of my goals as State Health Officer was to try to get more if not all of our local health officers and more providers on Kansas HAN so that they had access to these notices so they were – we are able to actually indeed be more effective in raising situational awareness.

And we certainly appreciate that. We do not want to over utilize the Kansas HAN or any other contact sources. Because people sometimes will just basically get information overload and they ignore it. So when we put these out, we do really prioritize and recognize that we want to make sure that they have a valuable impact.

So I would just say, yes, probably visit with your regional folks as to their preference if they are not on HAN and they have another preference of to be contacted. Perhaps by you, you get to be the central information resource. Maybe they only want to get a text message on occasion or whatever it may be that would be different. But I think you point out a good issue around the communication and so really finding out what their preference is, and the more we can get in Kansas HAN I think really the better.

Karen Luckett: Yes, me too. And, I was actually asked to kind of talk to a dental office that was really freaking out about Ebola based on what an EMT who is teaching CPR had told them, who also sells dental supply. So it's very opportunistic here. Where, all of sudden everyone needed this really high-tech shields and things – and they were very, very ignorant about everything.

There was a big yellow sign on the door saying, due to the risk of Ebola, which I took down right away, and went in and said, there is no risk to you or your patients. The risk is ignorance. And...

Robert Moser: Yes.

Karen Luckett: ... so then I informed them and they felt much better and I will include them, I will include the dental community. Because it is – they do have their hands in people's mouths and, it is a risk to them. So I will include them and are inviting them to the December 16th – some of those outliers who are now interested, it serves two things, it gets them accurate information about Ebola but it also shows them about health care coalition.

Robert Moser: Absolutely.

Karen Luckett: And their part in it, they do have a part in it. And, that's why there's so much ignorance out there is because they're not participating.

Robert Moser: Great point. Appreciate your efforts.

Karen Luckett: So we do need to let our hospitals know that there are opportunistic people out there that want to sell you a bunch of stuff.

Robert Moser: Yes, we certainly have heard a few of those and we have been trying to identify some of that and contacting folks when possible. Some of that also includes as we talked before about some of the laboratory vendors in selling the bio thread and MULTIFLEX screening test which I realize they'd like to know very quickly whether or not they're dealing with an Ebola patient. But for non-FDA approved testing it's a shot in the dark, you really still can't trust the information that they provide.

And there is a process in place to assure that not only do we get the screening test, from right now Nebraska Medical Center but also the confirmation testing from CDC before any act is made. And that – depending on how they are established to be high risk, the initial test being negative doesn't rule it out either. This is the reason we wait about 72 hours and retest to be absolutely certain if they're a high-risk exposed patient that they indeed do not have Ebola.

Karen Luckett: OK, these are – were my questions. Thank you.

Mindee Reece: Thanks Karen. Kristie we'll take one last question and then we'll need to wrap up this morning.

Operator: OK, there are no further questions at this time.

Mindee Reece: OK, great. Well thank you all for taking the time to speak with us this morning and we will be in touch with pertinent information via the Health Alert Network. And please consider registering for one of the upcoming regional health care coalition, Ebola Preparedness meetings. We'd like to see a good turnout from across disciplines. And have some regional specific conversations over the next few weeks.

Thank you all and have a good day.

Operator: Thank you for participating in today's call, you may now disconnect.

END